Abortion Self-care Journey:
Insights to Improve Experiences

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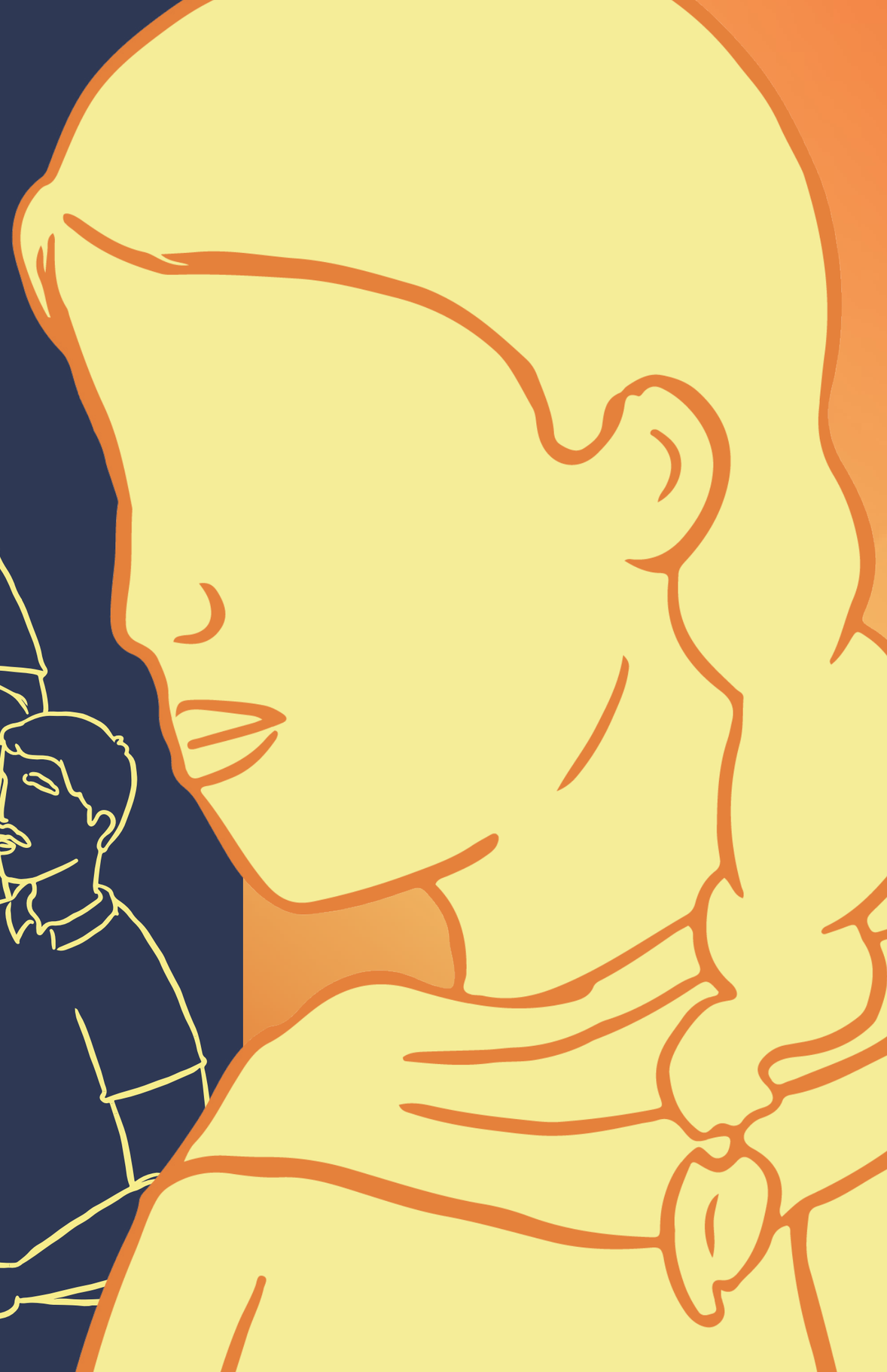

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Background

The World Health Organization's (WHO) definition of self-care in abortion is the ability of pregnant individuals to manage their unwanted pregnancies with or without the support of health care providers-particularly, in the early weeks of pregnancy (up to 12 weeks' gestation)[1]. The advent of medical abortion (MA) has made this possible, as early self-managed MA at home is a safe, acceptable and cost-effective method of pregnancy termination[2-7].

In alignment with WHO, Ipas defines abortion self-care (ASC) as an abortion conducted with medication without a prescription and the compulsory involvement of formal health systems or healthcare providers. ASC involves the entire journey of a woman (or persons who can get pregnant) from identifying a pregnancy, decisions around pregnancy outcomes, choices around method and place of abortion, and the personal and social aspects of an abortion. An integral part of the ASC journey involves the act of procuring abortion medicines and self-managing the abortion, this subset of actions within an ASC is defined as a self-managed abortion (SMA). In this document, the term SMA is used to refer to the discrete set of actions around the abortion and ASC to define the broader ecosystem level journey and its related actions. Given an abortion involves multiple discrete actions such as information seeking, decision making, procuring and accessing medicines, the abortion process and post abortion care, women could undertake and complete all or some of these actions by themselves with the choice to involve or not involve others in this process. The recent WHO guidelines recognize this aspect of medical abortion and provide recommendations to reflect the safety and efficacy across these tasks. Furthermore, WHO guidelines reflect the symbiotic relationship between the woman and the formal health system and its workers. It highlights their supportive role, and the various entry points to link to the health system if and should the woman desire their involvement[1].

An abortion incidence study in India, estimates that 11·5 million induced abortions (range 10·8–12·2 million; 73%) were medication abortions that took place outside of health facilities[8]. In addition to being a right of all women to have access to safe and high-quality abortion care, this analysis and others highlight the importance of abortion as an essential health care service supporting women and families to manage and attain their reproductive and demographic goals.

Abortion in India is legal on broad social or economic grounds[9], however the interpretation of the law and legal oversight for a healthcare service narrow down the scope and availability

of abortion services, and this is often compounded by perceived and real stigma and variable social norms. ASC in India is well documented from a public health and programming perspective estimating that most abortions in India are likely to be ASC and happen outside of the formal health system. However, women's perspectives and preferences to understand decisions, journeys and the ecosystem that enables, supports and in some cases inhibits the ASC journey have been less studied and documented in the past.

With emerging and consistent evidence[3] , ASC is a dynamic and often intentional act driven by a range of individual motivations ranging from desire for privacy to lack of choices and opportunities for abortion care within formal health systems. Abortion care in India and much of the world has seen a fundamental shift towards women centred and women led approaches for abortion care. Considering this and to ensure that abortion programmes are responsive and respectful of women's needs, there is an urgent need to better understand the key stakeholders, their roles and behaviours; understand the impact of community level social and gender norms to adapt programming efforts to improve abortion care.

This innovative research by Ipas Development Foundation (IDF) is an effort to systematically document and understand ASC journey through women's eyes and words. The aim of this research is twofold – first to understand and incorporate key findings into policy and programme initiatives and second, to bring key findings from women's voices to initiate discussions and dialogue with the broader community of individuals, collectives and institutions working towards improving safe, respectful, and high-quality abortion care.

Research Methods

The study used a qualitative design. Married women aged 18 and above were included in the study. Married women or their partners who accessed abortion drugs from pharmacies for SMA from October-2020 to March-2021 and voluntarily contacted the study team to participate were reached out for enrolment in the study.

Diaries are a useful method to document experiences in the natural context in comparison with other traditional methods of data collection. A 48-page, semi-structured diary was designed as a research tool, in which women could pen down their day-wise SMA journey. The diary was structured as follows:

- It began with a small number of retrospective questions around experiences and decisions on an unintended pregnancy. Including retrospective questions was important to understand the complete abortion journey since the decision to choose abortion would help in understanding the support systems and information pathways.

- This was followed by prospective questions covering aspects of abortion care around pathways, information sources, treatment protocols, physical and psychological experience during the abortion journey. A total of 21 days were provided in the diary so that women who face any complications can record their experience of managing complications.

- The final section of questions covered the post abortion experience including the views of women on the overall experience.

A detailed description of the research methods and the descriptive characteristics of the participants are

provided in "Self-Managed Abortion Journeys of Women: A research study using diary method in two states of India" [10].

While innovative and insightful, it is critical to note the limitations of this research. The study captures qualitative data from 2 states and may not completely represent all the experiences which a woman goes through during an abortion outside the health facility. The sample selected was only of married women from rural areas and therefore is not representative of experiences of all cohorts of women opting for abortion. Other relevant considerations include that women were recruited into the study after they experienced an unintended pregnancy thus providing limited and recall information around the early-stage pathways of women and couples before deciding to terminate an unintended pregnancy. Some of the diaries were completed by a volunteer and could have implications for the language used in the qualitative data. Furthermore, the study documents experiences as recalled and self-reported by the participants and therefore doesn't account for accuracy and recall bias.

Socio-demographic details of study participants

A total of 68 women completed the diaries. Study participants were mostly in the age group of 25-30 years (n=41), from a low socioeconomic stratum (n=33) with some level of education (n=53). Most of the women had at least one child (n=65), lived in the rural area (n=59) and were homemakers (n=58).

Fig 1: A conceptual framework for Abortion Self- Care in India

Social Experience

- Spaces-home and communities
- Roles-Household duties as a mother, daughter-in-law, wife, social relationships

Personal Experience

- Agency, spousal communication and trust key driver
- Information asymmetry during an abortion

Physical Experience

- Pregnancy Confirmation
- Side-effects of the medical abortion process
- Medical abortion - accessing, initiation and process

Key insights

Analysis of the data yielded insights around a range of themes both intended in questions included in the diaries and other relevant insights that were ancillary or adjacent to issues that were intentionally explored. A detailed analysis and set of insights are documented and discussed in the main report and this report provides additional insights emerging from the ASC journey for discussion and further exploration.

Analysis of the ASC journeys of these 68 women are unique to each one of them in ways small and large. While intensely personalised to their needs and circumstances, all of the ASCs reveal certain commonality in themes if not experiences. These commonalities and differences in experience have been summarised and depicted in the conceptual framework on abortion self-care (Fig 1) below.

This proposed framework is an attempt to help stakeholders map the different aspects of an ASC that impacts the woman's overall experience. The framework is derived from the formative insights of the abortion diaries and will require expert stakeholder consultations and additional research to revise, refine and validate to improve the overall experience of ASC for women in India.

Married women undergoing ASC in this research documented their experiences that can be grouped across three interconnected levels of the physical, personal and social experiences. The physical experience is at the core of the overall ASC experience and is defined by the experiences of women identifying a pregnancy, the use of medical abortion drugs to initiate an abortion, the clinical effects and side-effects of the medical abortion. ASC journeys in this research showed that the overall process involved organic information gathering, and sequential decision making that impacted the overall experience. In addition, there is significant divergence in the physical experience from current evidence and recommendations (see below discussion on insights from the physical experience).

The personal experience is centred around the individual as a whole and the importance of trust in people, processes, and systems within the ASC journey. Other dimensions of the personal experience also confirm the lack of risk perception, internalisation and preventive action identified in earlier research. However, this appears to be influenced by the current availability and growing community level experience of ASC as well. A critical finding of personal experience is the impact of significant information asymmetry. The lack of full information and accurate expectation of the abortion process played a key role in the experience of fear, nervousness and anxiety once the abortion process began (see below discussion on insights from the personal experience).

For all women in the study, ASC was at its core a physical experience defined by the effects of the medical abortion drugs used. These physical effects included both effects of the medical abortion drugs such as cramping, bleeding and expulsion of products of conception, and expected side-effects such as cramping, nausea, and pain. As expected, the intensity of these effects, how well the individual was prepared for it and managed these effects, especially the side-effects framed the overall ASC journey. However, the overall experience of an ASC was not purely based on the physical experience but was heavily influenced by a combination of physical experience within their individual expectations and societal roles and expectations. The diaries demonstrate that the ASC journey is experienced at the intersection of gendered roles as a wife, mother, daughter-in-law and its associated expectations within marriage, households and communities. This framing of the experience is a major driver for the choices and actions by women and their partners during the ASC around who is involved, preparation for the SMA and the level of support available to manage the abortion process. The social experience of ASC also demonstrates that these journeys are rarely solitary in nature and often involve different sets of stakeholders at various phases of the ASC journey. Overall ASC journeys are a social experience at the intersection of women's societalr roles intersecting across their personal and physical experiences of a SMA.

PHOTO CREDIT: Gyan Shahane / Unsplash

Social experience:

Abortion self-care is not limited to the index individual only

A key overarching theme from the diaries of the 68 women highlight that the interpretation and practice of ASC is not defined by the semantics of “self” as the individual only. The practice of SMA in all the diaries involved other individuals, often husbands, family members and friends. Only in a few instances were health workers and pharmacy workers involved during the journey. However, their roles were limited for information seeking before an abortion and to source medical abortion drugs only. Often, the abortion journey involves more than just the woman herself and it is evident from the diaries that women do not intend for this experience to be an isolated or isolating one, but are willing to include other individuals, who are often not trained health workers, with decisions based on trust rather than on level of knowledge or training on abortion care.

Firstly, I talked about this with my husband and with my sister and sister-in-law.

28-YEAR-OLD WOMAN, STATE 2

I first told my husband that there should be no problem with me after taking the medicine [for abortion]. So, I told my mother about my decision. If there is any problem during the abortion, then my mother can support me secretly [by maintaining confidentiality].

28-YEAR-OLD WOMAN, STATE 2

Yes, I spoke to my sister-in-law about taking an abortion pill. She helped me and told me that there is nothing to fear. In four to five days abortion will be completed.

25-YEAR-OLD WOMAN, STATE 2

I have talked about this with two females who come at sewing center. One who comes to learn sewing and one is my friend.

30-YEAR-OLD WOMAN, STATE 1

PHOTO CREDIT: Anderson Rian / Unsplash

Social experience:

Women's perceptions and expectations are not entirely aligned with a health system framing of abortion care as pre abortion counselling, abortion process and post abortion care

Traditionally, guidelines on abortion care are framed into a pre-abortion care, during abortion and post abortion care frames. However, the framing for a "self-care" approach, varies from this health system framing. In contrast to a framing of pre and post abortion demarcation, women documented a more dynamic approach to the abortion process. Key differences noted involve both passive and active information gathering often in a non-linear manner related to the entire abortion process. There was limited information gathered on the MA process itself (beyond the use of the pills to abort). This meant that women continued to receive information and contemplated decision making even after the SMA was initiated. Information seeking was needed to aid in decision making or to solve a specific problem that was being experienced.

Experiences shared in most of the diaries centred the entire process on identifying and ending an unwanted pregnancy but not a deeper understanding or action to prevent the risk of becoming pregnant. Only a few women in the study referred to prior contraceptive use and potential failure as reasons for this unwanted pregnancy. It is likely that the pre

When I decided to have an abortion, nothing was felt at the time. The only concern was to just get aborted.

26-YEAR-OLD WOMAN, STATE 1

I should have known about the side effects of the pills earlier.. I should have done abortion with all the information.

28-YEAR-OLD WOMAN, STATE 2

and post abortion framing has its origins from medico-legal guidelines and practice of abortion and not from a client centred approach.

Findings within the diary outline the motivation and action of women in designing pathways that are contextualised to their level of information (or knowledge on SMA), social support from family members and personal characteristics' such as a mobility and purchasing power indicating that ASCs are a highly personalised approach to abortion care.

Before doing abortion I was not aware of anything because this was my first child that's why I didn't had any information and during the process information was also not knowing.

23-YEAR-OLD WOMAN, STATE 1

PHOTO CREDIT: Paula Bronstein/Getty Images/Images of Empowerment

Personal experiences:

Information gathering about the ASC journey is a personalised, non-linear, multi-step process involving many sources and stakeholders

The desire for privacy and confidentiality around the abortion process was a key factor in choosing a self-managed approach. Chosen actions had a clear element of need for ensuring privacy and confidentiality across all stages of the ASC journey. However, it was also striking that while women desired and valued privacy, there were no women in this research who questioned or made comments on the legal status or validity of their decision to end a pregnancy,specifically using medical abortion drugs outside of a health facility. While the data did not have questions to probe further on the desire for privacy and confidentiality, it can be interpreted that stigma along with variable family support from extended family members, abusive relationships, cost of an abortion in a facility were some of the reasons for choosing a SMA.

Overall, the processes of information gathering, and decision making were intertwined across the ASC journey. Often information gathering involves a series of steps, utilising diverse channels to seek and obtain specific information to aid in a decision around a particular aspect of SMA (e.g., place and type of abortion, procuring medical abortion drugs, side effect management etc.). Often the information seeking and gathering process is not a singular discrete event. It is rather a set of steps with different drivers contributing to specific decisions around desired pregnancy outcome, type and place of abortion care, support/reassurance during an abortion and to a smaller extent information on post abortion care.

Yes, I thought of going to the doctor, but then if we go from home, everyone will ask where you are going, my children are small.. I do not know how long it will take in the hospital, children will get upset all day. Thinking of all this, I ate the medicine, this is a good way, no one will even know.

28-YEAR-OLD WOMAN, STATE 1

I was very afraid that if my mother-in-law would (get to) know, there would be a lot of problems. She will say a lot of things.

21-YEAR-OLD, WOMAN, STATE 1

In majority of the cases, women sought and accessed information on an ongoing basis rather than as one complete session (different from pre abortion counselling sessions). This was often driven by the needs of the individual to fill gaps around knowledge of SMA based on personal circumstances rather than as a standard set of information since women in this research had some level of background knowledge on abortion through pill. Information gathering about ASC can be grouped under three sub-domains based on the experience noted in these diaries. To supplement this, no woman in the study sought additional information to decide on either confirming or the outcome of the pregnancy.

Awareness about medical abortion pills including self-use: Most women (except a few) were aware of the option of abortion through pills. Many of these women had this as a passive knowledge and were able to trace sources from other women (aunts, sister, and sisters-in-law) and occasionally friends in their friends and family circles, and in some cases to prior experience of self-use of medical abortion.

Of note, health workers (ASHA, ANM, Anganwadi workers and pharmacy workers) were sought in a handful of instances to seek information on medical abortion. Although they were sought for information, they did not appear to play a role in decision-making to use MA and remained a small minority compared to instances of seeking information from family members (husbands, older women in family) and friends (of the woman and the husband).

Information on where and how to obtain medical abortion for self-use: The second major domain of information gathering was on where and how to procure abortion pills. This was straightforward through social networks where family or friends had purchased these pills earlier or through networks of friends of husbands who were able to share this information and/or guide them in this process. There were

I have heard about contraceptives like Mala-D on TV, and I have thought that there will be medicine for abortion too. My aunt has already had an abortion so I asked her, she told me that you tell at the medical store, he will give you the medicine for abortion.

30-YEAR-OLD WOMAN, STATE 1

I was not aware of the abortion pills. When I talked to “ASHA didi” of my village, she was the one who told me about the abortion pills.

27-YEAR-OLD WOMAN, STATE 2

In my knowledge, one or two women have taken these pills, so I already knew about the pills that when the foetus is one or two months old, then we can take the pills and the baby will be aborted.

24-YEAR-OLD WOMAN, STATE 1

My husband came to know about medicine by discussing it with his friends, medical stores and other relatives.

32-YEAR-OLD WOMAN, STATE 1

a handful of instances where the woman or her husband had a pharmacy worker friend/relative through which they were able to identify products and places to procure the pills. Women also drew on their own experience of using medical abortion drugs or from experiences of their close family members (elder sister, sisters-in-law, or aunt) or friends.

While women sought information on use of medical abortion drugs to manage this abortion outside of a health facility, some women did explore other methods to end an unwanted pregnancy prior to using medical abortion drugs. Approximately one sixth of all women in this group also considered other forms of an abortion including inaccurate options such as use of contraceptives. However, more concerning was the use of least safe methods such as decoctions, herbal remedies, drinking vinegar, “hot” foods. Of these a handful of them attempted insertion of organic items in the vagina before switching to medical abortion drugs.

Interestingly, none of the women in this group indicated that the medical abortion pills should be used only within a health facility, similar to a surgical method. The implicit understanding to use this product at home was perceived as a key advantage and well aligned to their needs. Given how pervasive the self-use of medical abortion drugs has been in this research, it is likely that awareness of this method (medical abortion) for “self-use” or for use outside of health facilities is perceived as an acceptable, convenient method building salience for it to be considered as the norm.

Contrary to past research[11], a high proportion of women themselves sourced the abortion pills from pharmacies. In some instances, women were also comfortable in seeking information from a pharmacy worker to gather additional details if needed on taking the abortion pill, potentially indicating a shift towards normalisation of SMA and increased agency of women to procure medical abortion drugs directly.

I came to know about abortion pills from my big sister and my sister-in-law, because they both had abortion from pills. From them I came to know about pills and medical shops.

28 -YEAR-OLD WOMAN, STATE 2

Before taking abortion pills, I tried other methods of abortion like Mala N Chhaya Goli, Antra injection, everyone knows about this but I found the method of pills right, because eating pills is a bit troublesome, but there is definite abortion.

26-YEAR-OLD WOMAN, STATE 2

My mother-in-law had brought some roots from a tree. Then she tied it with a thread and applied it to the bottom. Then that root was so prick, that it became difficult even for me to walk. When I started crying, my mother-in-law extracted that root.

24 YEAR-OLD WOMAN, STATE 1

Apart from women procuring the drugs, husbands played a key role in sourcing the medical abortion drugs. Within this research, apart from a handful of instances, pharmacy workers did not play a key role in the information provision or on the decision to undergo a SMA. In a few instances, women did indicate that the attitude of the pharmacy worker was a barrier to purchase drugs requiring either a prescription, detailed explanation of their personal circumstances or a repeat visit (rare).

Information on the abortion process: The third and most important domain related to efforts in understanding the abortion process through pills. This is the area where women had the least amount of information and invested limited efforts to gather more clarity prior to consuming the medicines and initiating an abortion. For many women in the research, the information that abortion can be achieved through pills and the sites from which they can be accessed was sufficient to make decisions and initiate action. Only a few women discussed the abortion process with other women in the family while a few women reached out to health workers (Accredited Social Health Activists and Auxiliary nurse midwives) or used digital mediums to understand the abortion process. Most women had a broad understanding that taking the pills will result in bleeding for 4 -7 days and then the abortion will be completed. Information on how to plan for a self-managed abortion, what to expect once the pills are consumed and danger signs that will need further medical attention and contingency planning for such emergency situations were deficient or not complete for most women in this research.

It is very likely that the paucity of information on it contributed to the primary emotions of fear, nervousness and anxiety (that the medicines should work and nothing untoward should happen) that most women experienced during the abortion process. Even among women who had experienced a prior abortion or knew of a close family member who had an SMA, there was a poor understanding of the abortion process, related side effects and its management.

I went myself to bring the pills. It is not tough to get. It is easy to get abortion pills, so I easily bought and ate them.

29-YEAR-OLD WOMAN, STATE 2

I myself went to the medical store to get medicine in the store in XXXX. Yes, since I was a woman, there was some problem, I connect to them with my husband on phone, he tells everything then the medical store person gave me the medicine.

32-YEAR-OLD WOMAN, STATE 1

Before eating the pill, I should have known that problems can come from the pill. When I got vomiting and latrine, I told the doctor that he told me that there are some problems, there is no reason to panic. But the family members got upset seeing my problems.

24 YEAR-OLD WOMAN, STATE 1

I was not at all aware that bleeding is so heavy and there is so much weakness during abortion. During this time, it is very important to be careful about the diet. during abortion, one should not stay in relation to the husband.

30-YEAR-OLD WOMAN, STATE 1

Personal experiences:

Decision making in ASC involves multiple sequential decisions that involves a set of trusted stakeholders

Decision-making in the SMA journey for all participants indicated a set of discrete decisions over a period. Commonly this involved decisions around the pregnancy outcome, place, and method of abortion, where and how to access medicines, decisions around taking the medicines and seeking supportive care. Decision-making during the ASC was complex and influenced by type and source of information on the specific steps of the self-managed abortion process (e.g., on buying the pills, taking the pills, managing the bleeding and side effects), while the decision to end the current pregnancy was a more straightforward one that was decided by the woman and her husband.

Decisions on the timing and desired outcome of the pregnancy were often joint in nature between the woman and the husband in a large majority of women in this research. In almost all such instances of joint decision-making, there was good convergence on the decision between the woman and her husband with the woman initiating discussions expressing a desire to end the pregnancy.

No woman in the study was forced to undergo an abortion against her wish and in many instances (approximately one-third participants) women were the primary decision makers to terminate the unwanted pregnancy. Almost all women (except two) were also supported by their husbands in their decision to terminate an unwanted pregnancy.

When I came to know about my pregnancy then I told this to my husband and we both took this decision together.

27-YEAR-OLD WOMAN, STATE 2

After coming home from there, we talked to the family about getting an abortion and my mother-in-law was refusing to let me have an abortion, and then agreed when I made her understand. This decision was taken with the consent of all.

30-YEAR-OLD WOMAN, STATE 2

Women's agency to initiate conversations, explain reasons behind their decisions/ preferences and convince other family members were evident across many of the responses. Often the key drivers for a decision to end the pregnancy were around financial pressures, the women's health and well-being and the family environment and their attitude. Records from the diary indicate effective spousal communication and the presence of vocabulary to discuss and decide on how to manage an unwanted pregnancy.

In some instances, past medical advice from doctors about risk to the woman's life if they became pregnant was etched in their minds. Women cited this as a key reason to terminate the pregnancy and do so outside of health facilities for fear of reprimand from doctors. In these instances, with the absence of health education to understand pregnancy related risks, women often based their decisions to end a pregnancy on such advice they had heard in the past.Only a small number of women in this cohort sought and obtained information on the entire process ahead of initiating the abortion and made specific contingency plans around support (e.g., confiding with the mother, arranging money needed, considering formal health facilities for emergency care). This is a unique feature of ASC, while with facility-based abortion care, key decisions and plans around critical aspects of the abortion care are often decided upon with a healthcare provider a priori.

A key feature that emerged, linked to the information seeking practices and different from a facility-based abortion process, is that since women do not have full and accurate information on the medical abortion process, a priori decisions on the SMA are only made up to the point of initiating an abortion process (e.g., decisions around the pregnancy, place and method of abortion, where and how to access medical abortion drugs, decisions around taking the medicines). Once women consume the medical abortion drugs and the process starts, they are then in a situation to make decisions related to managing their abortion process and

Both of us thought that in this era of inflation, we think that we should make our girls self-sufficient, and we have a small grocery store that runs our house, for all these reasons, I decided to abort.

28-YEAR-OLD WOMAN, STATE 2

I have an eight-month old daughter, how can I have a second baby? For keeping this child my body is also not ready. I still feel weak. If I carry a second child, then I would not be able to do the upbringing of my first child.

28-YEAR-OLD WOMAN, STATE 1

My studies have not been completed yet; my husband is also studying. We have to ask for money from others.. It is important that one of us starts earning, the last semester of my M.A. was not completed, I have to prepare for my job.

24-YEAR-OLD WOMAN, STATE 1

seeking additional care. Given that they do not seek information or are prepared for contingencies during the abortion process, they often experience stress and limited support for actions during the abortion process. This sequence of events often results in impacting the overall quality of their ASC experience.

Only a small number of women in this cohort sought and obtained information on the entire process ahead of initiating the abortion and made specific contingency plans around support (e.g., confiding with the mother, arranging money needed, considering formal health facilities for emergency care). This is a unique feature of ASC, while with facility-based abortion care, key decisions and plans around critical aspects of the abortion care are often decided upon with a healthcare provider a priori.

Both of our children were from the operation. The doctor had denied us for the third child because it was a threat to my life. As soon as I came to know from the [pregnancy] test I told my husband about pregnancy. Knowing this we both were very upset.

28-YEAR-OLD WOMAN, STATE 2

I took a lot of information before getting an abortion from my friend about - How is the medicine?, Where will I get this?, What to say to the shopkeeper?, How to take this?

25-YEAR-OLD WOMAN, STATE 2

Physical experiences:

Abortion experiences have some variability but almost always below current recommendations for a safe, dignified high quality abortion care experience

Most women recognized a pregnancy from a combination of missing their menstrual period and body changes. Women were also very familiar with the use of urine pregnancy tests to confirm a pregnancy in most cases with only a handful of them seeking consultation with a trained health worker to confirm a pregnancy. Almost all women were able to identify their pregnancy within 4 weeks of missing their period. Only women who were in postpartum amenorrhea or using hormonal contraceptives took a slightly longer time to confirm their pregnancies.

Another interesting finding was the absence of a conscious effort to date a pregnancy and establish clinical eligibility for the use of medical abortion and its appropriate dose. Knowledge around gestational age limits for the self-use of medical abortion pills currently available in India was limited to only a few women and often based on past unsuccessful experiences of using it in advanced pregnancies (in the second trimester). In this cohort, since most women identified their pregnancy within 2 months of the last menstrual period followed by the decision to initiate an abortion process, it is unlikely that any of them underwent an SMA in their second trimester. This is an area that would benefit from further exploration in future research to ensure that safety for SMA is not compromised and to better understand women's understanding of gestational ages up to which SMA is safe based on current evidence.

As soon as my month changed, I immediately checked with the testing machine. It came in two red coloured lines, seeing the line, I understood that the matter was wrong [Pregnancy confirmed]. I immediately went to my relatives' medical store and immediately brought abortion pills. Apart from this, there was no choice, I have no money.

40-YEAR-OLD WOMAN, STATE 1

Two years ago, I took an abortion pill, and at that time my abortion happened but I faced problems because the pregnancy was of 2.5 months. Then I went to a private hospital for abortion and lots of money was spent on that.

35-YEAR-OLD WOMAN, STATE 1

Access to medical abortion pills was not a challenge for women in this research. The use of co-packaged mifepristone and misoprostol (combipack) is universal in this research with all women using a combipack. Few women mentioned facing some barriers in the form of pharmacy workers insisting on a prescription, but they were still able to source the pills after an explanation, obtaining a prescription or from other alternate outlets.

As expected, women were not brand specific in their recall of medical abortion drugs and in most of the cases, the pharmacy worker was not an active stakeholder in the decision to purchase and use medical abortion drugs. Cost of the combipack was between 300 -600 Indian rupees with no explicit evidence of women paying a higher cost for obtaining the pills without a prescription or other “risk premiums” for the product.

While all women in this research used the combipack, the combination regimen is still complex for most women. Among this cohort all but 3 took mifepristone orally as indicated while three women consumed mifepristone and one tablet of misoprostol on day 1. Even more interesting to note were the discrepancies in the misoprostol dosing against current recommendations. Forty-eight hours after taking the mifepristone, almost all women in this cohort had only taken two pills of misoprostol. While some women did not take further misoprostol, others took the additional doses between days four to eight. The route of administration for misoprostol was often considered to be complex and barring two women, the others did not follow current recommendations and received a sub-optimal dose of misoprostol (2 – 4 tablets over two – eight days). In most cases misoprostol was also swallowed with water or milk similar to other tablets.

I went myself to bring the pills. It is not tough to get. It is easy to get abortion pills, so I easily brought and ate also.

29-YEAR-OLD WOMAN, STATE 2

I got the abortion pills through my husband from “Market XXX” which is a small market.. There was not such difficulty in taking this pill.

19-YEAR-OLD WOMAN, STATE 2

My husband went to 2-3 medical stores, but one- two people said that this medicine is not available at their medical store. One of the medical store owners said that pills are available, but he will give them after seeing a prescription from a doctor. When my husband told them about the problem, the medical store owner gave the medicine after huge difficulty.

33-YEAR-OLD WOMAN, STATE 1

Another key area that impacted the quality of SMA was the poor knowledge and practice of using supplementary care, particularly pain medication and side effect management. Only a few women decided to seek and use additional medications during the abortion process, often after the process had been initiated. Supplementary medications used were predominantly for the abdominal pain and cramps taken from day 3 onwards, these were iron supplements and energy syrups to address tiredness.

Finally, women were able to self-report completion of an abortion with three quarters of all women indicating that the abortion was complete by day 10. Among the few women who continued to have bleeding, they too confirmed completion by day 14. While the tool did not specifically ask around post abortion care, for most women, the end of the abortion process indicated success in their health goal.

Yes, after 24 hours of taking the big pill [mifepristone] , took two small pills with milk, because earlier took with plain water, it felt very heavy. So, this time took it with milk and did not take any other pills.

DAY 2, 21-YEAR-OLD WOMAN, STATE 1

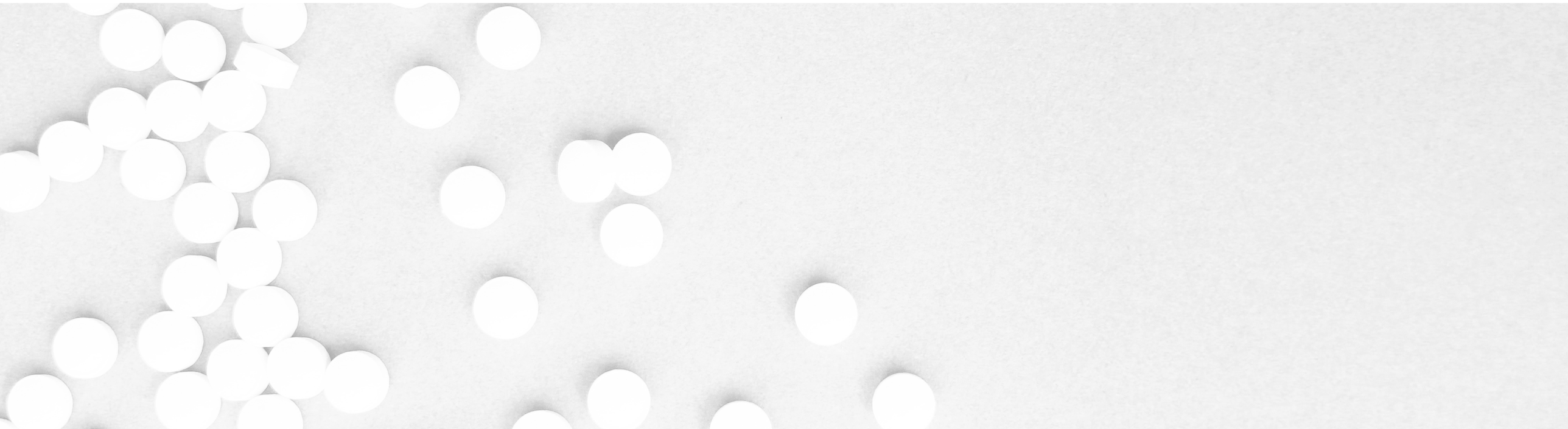
Today I have taken one pill [misoprostol] for abortion. I took pill with jaggery tea as yesterday.

DAY 2 - 28-YEAR-OLD WOMAN, STATE 2

Since yesterday, when I started getting blood, I did not take medicines and burned the remaining pills in the stove.

DAY 2, 28-YEAR-OLD WOMAN, STATE 1

PHOTO CREDIT: Hal Gatewood / Unsplash



Areas for further discussion

Safety of abortions have historically revolved around the biomedical framework and relied on measures and standards for the clinical processes with a focus on the provider, facility and the method (of abortion) adopted[12]. Given that most abortions in India happen outside of this biomedical framework, there is a need to evolve safe abortion interventions (across policy, advocacy, research and programme) to encompass the social, personal and physical dimensions of the ASC. A few relevant topics for further discussion considering the above findings are given below.

1.

As demonstrated across the research, ASC in India is far from a “solo” journey for married women with a varied range of roles for the different stakeholders beyond the woman undergoing the abortion. The categories of stakeholders in an ASC are highly context specific and often not involved in traditional safe abortion programmes (e.g., role of the older women and social contacts, networks). In order to improve the overall experience of an ASC, a comprehensive mapping and understanding of the roles of different actors involved in an ASC journey can be undertaken through further research and exploration.

2.

ASC in India is prevalent as a result of tangible (e.g., widespread, easy and affordable availability of medical abortion drugs) and intangible (e.g., perception that MA is to be used at home or by self) facilitators. Critical to expanding access to safe abortion will include the recognition, protection and evolution/ growth of these facilitators.

3.

ASC is primarily a community-based programming effort and not a health system-led programming effort. Recognizing this difference and adapting programme inputs and interventions to this will help centre the woman at the heart of an ASC journey and improve the experience of abortion self-care in India. For e.g. In the domain of information seeking, the current situation requires on-demand access to specific and complete information for SMA when women and couples are faced with an unwanted pregnancy instead of an active information seeking behaviour.

4.

ASC in its current form is of a highly variable quality and often a sub-par experience for most women across domains of information, decisions and the physical experience. Several critical and tangible gaps such as lack of information on what to expect, supplementary care for abortion and social support are lacking in current program initiatives. These need to be addressed to improve the quality of an ASC experience in India.

5.

Abortion continues to be a stigmatised issue in India. While ASC is a conscious attempt to mitigate or overcome some of the known drivers of abortion stigma, it is critical to recognize that ASC does not bypass all drivers of stigma. Stigma around accessing care during an SMA from the health system, variability in social sanction, approval for a SMA and perceptions of irresponsibility with ASC are some examples that are continued drivers of abortion related stigma identified in this research.

Next steps

Future areas for exploration

The research methodology adopted to document experiences and map the ASC journey is innovative and offers rich insights, there is a clear opportunity to further refine and improve this research methodology with an aim to improve abortion care experiences for women and girls. A few considerations for the future can be:

- Attempting to document the journeys of women and couples from the preconception stage to understand baseline behaviours related to fertility management and decision tree around pregnancy prevention and termination.
- Adapting consent procedures to enable follow up interviews of participants in near-time or post completion of ASC to gather deeper insights around specific phases (e.g., obtaining pills, receiving supportive care during SMA, post abortion care and complications etc.)
- Considering the use of audio diaries to simplify data collection and identify vocabulary used in relation to abortion care (and specifically to ASC).

Building on this formative research, options for revising the tool (abortion diary) and the methodology (recruitment, timing and topics) with an aim to gain a nuanced understanding of ASC in India can be considered. Adopting a more open-ended tool design might be more formative in identifying domains relevant to ASC that may have been currently missed.

The relationship between self-care and empowerment isn't documented well among the different advantages of self-care and particularly so for abortion in the Indian context. Utilising this approach, there is an opportunity to study the nature of relationship (association, causality, pre-conditions, amplifying effect etc) between ASC as an act of empowerment or an empowering action.

In partnership with the research community, efforts to further develop the methodological features of this approach can be identified, particularly for abortion self-care and possibly other stigmatised health behaviours.

Although ASC can be a personalised experience (non-standardized) there are discrete time windows during which specific support can contribute to an improved overall abortion experience. A couple of specific opportunities for discussion / consideration include:

- Information provision that is tailored to the ASC journey - what messages should be included to, revised in and replaced from existing interventions?
- Discuss and agree on efforts to improve the quality of an ASC experience, particularly the physical experience that has an impact on the personal and social experiences. Specifically issues around treatment protocol adherence, what to expect (in terms of bleeding), supplementary care as a standard, access to basic commodities like sanitary napkins and better linkages to other health services should be addressed urgently.
- Attempt to undertake a larger-scale research effort to validate key findings from this formative work – specific topics for consideration could include
- Spousal communication and its role in ASC

    - » Social networks and trust-based relationships that influence ASC
    - » Explore critical time points in an ASC journey that have the greatest impact on the overall quality of selfcare experience
    - » Potential program and policy interventions that could bolster support for ASC and particularly the social aspects of an ASC.

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